NC Health Choice for Children:

Frequently Asked Questions For Mental Health Providers

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GENERAL INFORMATION

Q1. ***What is NC Health Choice for Children?***

A. It is a fee-for-service health insurance program that provides free or low-cost coverage to uninsured children under the age of nineteen whose families cannot afford private health insurance and who do not qualify for Health Check (the Medicaid program for children). The program was established in 1998 by the federal government and the State of North Carolina. It is modeled after the North Carolina Teachers and State Employees Comprehensive Major Medical Plan (State Health Plan) with some additional benefits. The Claims Processing Contractor is Blue Cross/Blue Shield of North Carolina (BCBSNC).The behavioral health benefit is administered by ValueOptions, a national company specializing in this type of care.

Q2. ***How do children enroll?***

A. Families complete a Health Check/NC Health Choice Application Form which can be obtained from a local department of social services office, by calling the NC Family Health Resource Line at 1-800-367-2229, or by going online to www.dhhs.state.nc.us/dma/cpcont.htm. (Click on "NC Health Choice for Children Information and Application" (in English or Spanish). Children who apply for Health Check/NC Health Choice are first screened to determine if they are eligible for Health Check. They are enrolled in Health Check or NC Health Choice based on their age and the income level of the family.

For information about how you can help families enroll, please see Appendix D.

Q3. ***What services are covered under NC Health Choice for Children?***

A. NC Health Choice for children is a comprehensive health insurance program covering a range of services for children. These include acute and preventive care services, hospitalization, and special hearing and vision benefits. Prescription drugs are covered. Dental benefits include prophylactic, evaluative and therapeutic services. Benefits for children with special health care needs (CSHCN) are similar to those covered by Health Check (Medicaid). For more details on NC Health Choice covered services refer to the member handbook online at www.dhhs.state.nc.us/dma/cpcont.htm. (Click on "NCHC Handbook").

Q4. ***How will I know that an individual is a member of the NC Health Choice for Children plan?***

A. Children will have a card identifying them as members of the NC Health Choice for Children Plan.

Q5. ***How long are children enrolled? Will I be reimbursed for services if families fail to re-enroll their children****?*

A. Children are enrolled for 12 continuous months. The expiration date is on the card. Health Check/Health Choice is not renewed automatically. *Providers should review the certification period at each visit and remind patients to start the re-enrollment process 2 months prior to the end of their certification period. The re-enrollment packet will arrive in the mail.* If the patient is found to be ineligible, providers will not be reimbursed by Health Choice for services that occur after the original termination date.

Very rarely, it is possible for benefits to end prior to the date stamped on the card. This could occur if a child reached the age of nineteen prior to the end date, became eligible for Health Check (Medicaid) or was found to have other insurance coverage.

To verify the member's enrollment status call: 1-800-422-4658

Q6. ***When a member reaches the maximum age of 19 years old, are they covered through the end of that month?***

A. Yes

Q7. ***Does the patient need authorization from the primary care physician to see a mental health provider?***

A. No. However, the service provided must be part of the covered benefit in order to receive reimbursement. ValueOptions, Inc. must pre-certify[1] all care with the exception of the first 26 unmanaged outpatient visits each fiscal year (July 1 through June 30). For more detail, see information in PRE-CERTIFICATION section of this document or the mental health section of the benefit book online.

Q8. ***Does the NC Health Choice plan have pre-existing condition waiting periods?***

A. No.

Q9. ***What is the administrative link between Medicaid and NC Health Choice for Children?***

A. The state's Medicaid agency, the Division of Medical Assistance, is responsible for setting eligibility policies, overseeing eligibility determination in county departments of social services and assessing the program performance of NC Health Choice. The State Health Plan/BCBSNC is responsible for the benefit structure and processing and payment of claims for the program. ValueOptions, Inc. is the administrator for the behavioral health benefit and manages this part of the program. The Division of Public Health/Children and Youth Branch is responsible for outreach and marketing efforts to enroll children in the program. This division also oversees the enhanced coverage of Children with Special Health Care Needs (CSHCN) as defined in the legislation.

BECOMING A MENTAL HEALTH PROVIDER UNDER NC HEALTH CHOICE:

Q10. ***Which mental health, alcohol and drug treatment professionals are qualified to provide care or treatment under NC Health Choice.***

A. The professionals qualified to provide treatment are listed in the "NC Health Choice Handbook" (the family's benefit booklet). The 2004 edition is available online at**:** www.dhhs.state.nc.us/dma/cpcont.htm

For a list of qualified providers see Appendix A.

Q11. ***How about provisionally licensed providers? Can they bill for services?***

A. No.

Q12. ***If an outpatient mental health provider is qualified, what do they need to do to enroll in NC Health Choice for Children?***

A. No enrollment is necessary. They just have to meet the qualifications in Appendix A. (See Question 21).

Q13. ***If a mental health provider is employed by a program/facility, do they need to enroll individually?***

A. No, they do not enroll individually and billing is done by the program/facility.

[1] This term is the same as pre-authorize.

COVERED MENTAL HEALTH SERVICES

Q14. ***Are mental health and substance abuse services both covered?***

A. Yes.

Q15. ***What specific services are covered?***

A. Basic benefits include treatment in the following settings: outpatient (offices or clinics), inpatient facilities, residential treatment centers, partial hospitalization programs (PHP), intensive outpatient programs (IOP), and 23 hour crisis stabilization units. (See Q17 for additional benefits/special services).

Q16. ***Does NC Health Choice cover early intervention mental health services such as psychosocial screening and situational crisis intervention?***

A. Yes, NC Health Choice provides for up to six "early intervention" outpatient visits. These are billed as "early intervention visits" and do not require an Axis I psychiatric or chemical dependency diagnosis. Up to two visits may be billed with no diagnosis by using the code 799.90 for assessment. The remainder of the six are then billed with a V-code if there is no Axis I diagnosis.

Refer to Appendix B for details as well as the CPT Codes to use for these services.

Q17. ***What special services for mental health are covered?***

A. Special services constitute additional benefits for children with documented medical necessity. Currently these include Community Based Services, Day Treatment, Residential Services and Intensive Case Management. In addition, Community Based Rehabilitative Services and Targeted Case Management services are covered as medically necessary for very young children with developmental disabilities.

For information regarding the criteria for special services and to determine which services may be covered for a particular child, call: 1-800-753-3224.

Q18 ***Is family therapy a covered benefit under NC Health Choice?***

A. Yes.

Q19. ***When behavioral health care providers consult with parents, school-based personnel or other professionals in the community regarding a specific student's health or mental health issues, is this service covered? Can it be billed separately?***

A. These types of consultations are considered part of the basic service being provided, and therefore are not covered separately.

Q20. ***Will NC Health Choice pay for case management services? If yes, is there a specific definition of what is meant by "case management"?***

A. Yes, **intensive** case management services are reimbursable but require pre-certification. In order to be considered a billable service, the case management provided must be multi-agency, multi-modality care coordination when there is a primary psychiatric or substance abuse diagnosis as defined by DMH/DD/SAS.

REIMBURSEMENT AND BILLING

Q21. ***How is a provider reimbursed for a service?***

A. Claims are filed with BCBSNC using CPT codes on standard HCFA 1500 forms. Approximately 90% of the claims are paid within 30 days. Forms should be submitted using the NC BlueCross BlueShield provider number, if available, and the federal tax identification number. If a provider is not enrolled, the federal tax identification number is all that is needed. However, having a BCBSNC provider number facilitates processing the claim.

To obtain a provider number, contact the customer service line at: 1-800-422-4658.

Provider numbers are not issued for intensive case management, community-based services, day treatment, therapeutic foster care or group homes,

Q22. ***How much is a provider reimbursed for service?***

A. Currently, reimbursement rates are 100% Usual, Customary, and Reasonable (UCR) established by BCBSNC (based on the Cost Wise Program). Participation in Cost Wise is not required. Reimbursement will be made directly to the enrolled provider of record.

Q23. ***If a service is covered, can I bill the NC Health Choice for Children member for the difference between my charges and the BCBSNC reimbursement?***

A. No, for covered services you cannot bill a NC Health Choice for Children member any amount other than the co-payment, if applicable.

Q24. ***Can I bill members for services that are not part of the benefit package for NC Health Choice for Children***?

A. Yes. You can bill members for services that are not a part of the benefits package.

Q25. ***How do I bill for an initial psychiatric evaluation?***

A. Unless billing for an early intervention visit, the provider should use CPT 90801 or 90802 on a HCFA 1500 claim form.

Q26. ***What diagnosis coding system is used to bill for mental health services - DSM IV or ICD-9?***

A. BCBSNC prefers the ICD code. Both are recognized. Note that behavioral health visits may not be billed under a physical health diagnosis code.

Q27 ***Is it necessary to administer the Child and Adolescent Functional Assessment Scale (CAFAS) in order to bill for High Risk Intervention?***

A. Not absolutely. A comparable instrument may be used. ValueOptions requires some type of assessment tool be used, not necessarily the CAFAS.

Q28. ***What documentation is required when billing for a mental health service?***

A. Documentation should be done in accordance with professional guidelines (i.e., assessment, treatment plan, progress notes, etc.). Treatment notes must clearly document symptoms, functioning, and progress toward measurable goals.

Q29. ***When would additional documentation be required*?**

A. If a request is to be made for more than 26 visits, the provider completes and submits an OTR (Outpatient Treatment Report) to ValueOptions, Inc., prior to the 26th visit. ValueOptions may request additional information if an appeal is being processed for non-certification. In addition, BCBSNC, the Claims Processing Contractor, may request additional information within the first 26 visits if there is a question about the appropriateness of payment.

Q30. ***What should I do if I do not agree with a decision to deny a claim, or if I disagree with the reimbursement provided?***

A. The same appeals processes that are established for the State Health Plan are also available for NC Health Choice for Children for clinical denial of services. The appeals process for behavioral health services is outlined in each non-certification letter.

For more information call the Appeals Coordinator for Health Choice at:
ValueOptions: 1-800-753-3224

If you are concerned about denial of reimbursement for services that have been approved by NC Health Choice or about the rate of reimbursement for approved services, please contact BCBSNC, the Claims Processing Contractor at 1-800-422-4658.

Q31. ***Is it possible to stop an Explanation of Benefits Form (EOB) from being mailed to the parent if the service provided was a confidential service?***

A. No, an EOB is mailed anytime a service is provided and billed to NC Health Choice.

Q32. ***If a child comes in for a well child check-up or a primary care visit on the same day that they are seen for an initial psychiatric evaluation or a psychotherapy visit, can both be billed on the same day?***

A. Yes, both the physical health and mental health visits may be billed on the same day. However, the physical health claim must not be filed with a mental health procedure code.

PRECERTIFICATION[2]

Q33. ***Is precertification needed for all behavioral health care (mental health and substance abuse)?***

A. Yes, with one exception. Precertification is not necessary for the first 26 outpatient psychotherapy visits during the Plan Year (July 1 through June 30). All other services must be precertified by calling 1-800-753-3224 prior to the beginning of treatment.

For more detail, see below.

Q34. ***What should a provider do if treatment is expected to continue beyond 26 visits?***

A. If treatment is expected to continue beyond 26 visits, providers should request approval from ValueOptions, Inc. prior to the 26th visit. At that time, providers must submit an Outpatient Treatment Report which may be obtained from ValueOptions, Inc.

For copies of the form or more information, call 1-800-753-3224.

[2] Note: This is the same as pre-authorization.

Q35. ***How are the 26 visits counted?***

A. The 26 visits include all outpatient "office-visit-type" mental health services the patient receives during the plan year even if rendered by more than one provider (i.e., the 26 visits are combined for early intervention behavioral health, mental health and substance abuse visits across all providers). An exception is made when a psychiatrist bills for medication management visits using CPT Code 90862. CPT 90862 is not excluded from the 26-visit count when the claim is being filed with a substance abuse diagnosis.

For example:

- A 30-minute individual therapy session equals one visit toward the 26.
- A 50-minute psychotherapy session equals one visit toward the 26.
- A ½ hour, 1-hour or 1 ½ hour group therapy session counts as one visit toward the 26.
- One psychological testing session counts as one visit.
- The six "early intervention" visits count toward the 26 unmanaged visits.

BCBSNC cannot determine how many visits the patient has had. BCBSNC can only report how many claims have processed on a "first received" basis, regardless of when the service was provided. Coordination of CPT billing as well as service provision is important when more than one provider is treating a patient.

Q36. ***Does inpatient treatment need to be precertified?***

A. Yes, inpatient treatment is covered, but precertification is required from ValueOptions, Inc. before the patient is admitted.

Call 1-800-753-3224 to obtain precertification.

Q37. ***What happens if precertification has not been obtained? Can I bill the member for these services?***

A. No. If precertification is not obtained before admission, the member may not be billed for the non-precertified services. Nor can the family be billed for services that have been denied based on medical necessity.

Q38. ***Does psychological testing require precertification?***

A. Not always. No precertification is required when psychological testing is done within the first 26 unmanaged visits. One outpatient testing session counts as one visit. However, all other psychological testing, including that which is administered while as an inpatient, during a partial hospitalization, intensive outpatient program (IOP) or residential treatment center (RTC), requires precertification prior to the testing.

For codes see Appendix B. For approval, call 1-800-753-3224.

REIMBURSEMEMENT FOR HIGHER LEVELS OF CARE

Q*39.* ***How are claims filed for higher levels of care – i.e., inpatient, residential treatment centers (RTC), partial hospitalization (PHP), intensive outpatient program (IOP) services, 23-hour stabilization*?**

A. These claims are filed via standard revenue codes on a UB-92 claim form. See Appendix B for specific codes to be used for IOP.

Q40. ***How do the requirements for residential treatment centers (RTCs) and group homes differ?***

A. **Residential treatment centers** are covered when precertified and medically necessary under the basic benefit, which requires state licensure for residential treatment, national accreditation (JCAHO, CARF, COA), 24-hour licensed RN staff and an attending or consulting psychiatrist or addictionologist. If the physician is "consulting," there must be evidence of the physicians involvement in the development of the treatment plan and on-going revisions to the treatment plan as necessary.

B. **Group homes** licensed by the Division of Facility Services are covered when pre-certified and medically necessary under the Special Services benefit. Separate criteria have been developed for making medical necessity decisions for group home and therapeutic foster home admissions for NC Health Choice children.

C. **Therapeutic Foster homes** licensed by the Division of Social Services are also covered.

APPENDIX A: QUALIFIED OUTPATIENT MENTAL HEALTH PROVIDERS

- **Licensed psychiatrist (MD)** or (**DO**)
- **Licensed psychologist** (**PhD)**, (**EdD)** or (**PsyD**)
- **Certified clinical social worker** (**CCSW**)
- **Licensed clinical social worker** (**LCSW**)
- **Licensed professional counselor** (**LPC**)
- **Licensed marriage and family therapist (LMFT)**
- **Certified fee-based pastoral counselor (PhD)**
- **Licensed psychological associate** (**LPA)**; for services prior to 01/01/04 must have been supervised **and** employed by a licensed psychiatrist or licensed psychologist
- **Licensed physician assistant**; must be supervised **and** employed by a psychiatrist
- **Certified Clinical Specialist in Psychiatric and Mental Health Nursing** (RN, certified by the American Nurses Credentialing Committee which now certifies clinical specialists as Advanced Practice Registered Nurse, Board Certified,)
- **Registered nurse** (**RN)** or (**RN-C)**; must be supervised and employed by a licensed psychiatrist or licensed psychologist

For alcohol and drug problems only:

- **Certified substance abuse counselor (CSAC)**
- **Certified clinical addictions specialist (CCAS)**
- **Certified clinical specialist (CCS)**
- **Physician (MD) or (DO);** licensed as an MD or DO in the state in which services are provided, and be certified by the American Society of Addiction Medicine.

APPENDIX B: FREQUENTLY USED CODES

Initial Psychiatric Diagnostic Interview Examination*

90801
90802

* *Do not* use for early intervention visits

Individual Psychotherapy with Mental Health Diagnosis*

90804 – 90815
90853

* Requires credentialed provider. Group therapy permitted if each group member has Axis I diagnosis with therapy for each member billed by appropriately credentialed provider.

Psychological Testing*

96100

* One session which counts as one visit toward the twenty-six unmanaged visits.

Case Management Services*

T1017HE

* Requires precertification. In order to be considered a billable service, must be multi-agency, multi-modality care coordination when there is a primary psychiatric or substance abuse dx.

Family Psychotherapy

90846-90847

Medication Management*

90862

- Does not count toward the twenty-six unmanaged visits unless there is a Substance Abuse Dx.

Intensive In-home Services

S9480 (Procedure code to use with a primary psychiatric diagnosis)
S9475 (Procedure code to use with a primary substance abuse diagnosis)

- Does not count toward the twenty-six unmanaged visits;
- Must be precertified by ValueOptions' Clinical Care Manager as medically necessary prior to the start of treatment.
- Provider of intensive in-home services must be approved by Charlotte Craver (1-800-753-3224, extension 5324) prior to beginning work with the child/family. Once approved, the provider is eligible to work with other families if precertified as medically necessary by the Clinical Care Manager (see above bullet).

Early Intervention/Risk Reduction Visits*

99401	Individual	15 minutes (counts as 1 visit)
99402	Individual	30 minutes (counts as 1 visit)
99403	Individual	45 minutes (counts as 1 visit)
99404	Individual	60 minutes (counts as 1 visit)
99411	Group	30 minutes (counts as 1 visit)
99412	Group	60 minutes (counts as 1 visit)

* Up to 2 of the 6 visits may be billed using code 799.90 without an Axis I psychiatric or chemical dependency diagnosis, thus allowing 2 visits for assessment purposes. The remainder of these 6 visits must be billed with a V-code if there is no Axis I diagnosis. This means the following combinations of 6 visits may be billed and reimbursed as part of the twenty-six unmanaged visits each plan year:

  1 visit filed as 799.90 / 5 with a V-code
  2 visits filed as 799.90 / 4 with a V-code
  0 visits filed as 799.90 /6 with a V-code

Treatment in an Intensive Outpatient Program (IOP)*

*This is a structured, multi-modality treatment program and is not the traditional 1:1 office-based psychotherapy or group therapy.

Claims for this service are filed using the revenue codes (listed below) on a UB-92 claim form.
944 – IOP for substance abuse or dependence
945 – IOP for alcohol abuse or dependence
912 – IOP for psychiatric disorders

APPENDIX C: FREQUENTLY USED PHONE NUMBERS

TO ENROLL AS A PROVIDER	1-800-422-4658 Ask for the State Health Plan/NC Health Choice Provider Relations Representative.
TO VERIFY ELIGIBLITY	1-800-422-4658 Follow the prompts for NC Health Choice for Children.
FOR PRECERTIFICATION	1-800-753-3224
TO ENROLL FAMILIES	1-800-367-2229 - North Carolina Family Health Resource Line For more information or to get an application.
TO APPEAL	1-800-753-3224 Ask for the Appeals Coordinator for NC Health Choice.
TO VERIFY CURRENT BENEFIT PACKAGE	1-800-422-4658 Follow the prompts for NC Health Choice for Children.
TO VERIFY CRITERIA FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS	1-800-753-3224 Ask for the Account Representative.
TO INQUIRE ABOUT ELIGIBLE PROVIDERS OF SPECIAL SERVICES	1-800-753-3224 Ask for the Account Representative.

APPENDIX D:
FIVE STEPS TO HELP UNINSURED CHILDREN ENROLL IN HEALTH CHECK / NC HEALTH CHOICE

Step 1:

Become familiar with Health Check / NC Health Choice so that you can describe the major features of our state's child health insurance programs to the families you serve.

To learn more about Health Check / NC Health Choice, go online to **www.nchealthystart.org**. Click on the Health Check / NC Health Choice logo in the left margin. This family-friendly web site provides information and links to benefits booklets and application forms.

Step 2:

Order free Health Check / NC Health Choice outreach materials and application forms from the NC Healthy Start Foundation to distribute to families.

Orders can be placed online at **www.nchealthystart.org** or by calling Margaret at 919-828-1819.

Step 3:

Tell uninsured families in your practice that Health Check / NC Health Choice may be for them!

Refer interested families to the local Department of Social Services (DSS), the Health Check / NC Health Choice Family Web Site at **www.nchealthystart.org**, or to the NC Family Health Resource Line:

- 1-800-367-2229 (English and Spanish)
- 1-800-976-1922 (TTY for the hearing Impaired)

The line operates Monday through Friday from 8 a.m. to 5 p.m.

Step 4:

Identify staff in your practice who can help families with the application process. Training is available through most local DSS agencies.

Step 5:
Become involved in local outreach efforts.

You can find the name of the lead Health Check / NC Health Choice outreach contact in your community by going online to:

http://www.nchealthystart.org/outreach/index.html
(Click on "County Info" in Right Column; then click on County Name).